



Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640



Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION
LAST NAME: FIRST NAME:
PHONE NUMBER: DATE OF BIRTH:
STREET ADDRESS:
CITY: STATE: ZIP CODE:
PATIENT INSURANCE ID NUMBER:

MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES:

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: https://magellanrx.com/member/external/commercial/common/doc/en-us/phi\_disclosure\_authorization.pdf

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:

PRESCRIBER INFORMATION
LAST NAME: FIRST NAME:
PRESCRIBER SPECIALTY: EMAIL ADDRESS:
NPI NUMBER: DEA NUMBER:
PHONE NUMBER: FAX NUMBER:
STREET ADDRESS:
CITY: STATE: ZIP CODE:
REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION
MEDICATION NAME:
DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: QUANTITY:
NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:
DURATION OF THERAPY (SPECIFIC DATES):

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MEMBER'S LAST NAME: MEMBER'S FIRST NAME:

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO

Table with 3 columns: MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):, DURATION OF THERAPY (SPECIFY DATES):, RESPONSE/REASON FOR FAILURE/ALLERGY:

2. LIST DIAGNOSES: ICD-10:

- checkbox Narcolepsy with cataplexy
checkbox Narcolepsy with excessive daytime sleepiness
checkbox Other Diagnosis ICD-10 Code(s):

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For all diagnoses, answer the following:
Is the prescriber a sleep specialist or neurologist?
Select if the following applies to the patient:
checkbox A polysomnography (PSG) sleep study consistent with narcolepsy
checkbox A Multiple Sleep Latency Test consistent with narcolepsy
checkbox Chart notes or consultation report documenting diagnosis
\*Please provide supporting documentation.

For narcolepsy with excessive daytime sleepiness, also answer the following:
Is the patient concurrently taking a sedative hypnotic?
Has the patient had a previous trial with standard stimulants such as methylphenidate, dextroamphetamine, or amphetamine/dextroamphetamine?
\*Please submit supporting documentation showing date(s) of trial(s).
Has the patient had a previous trial with generic modafinil (Provigil) or Nuvigil (armodafinil)?
\*Please submit supporting documentation.
If "no" to the above question, is the patient not a candidate for generic modafinil (Provigil) or armodafinil(Nuvigil)?
\*Please submit supporting documentation.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.





Xywav (calcium,potassium,magnesium,sodium oxybates)

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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.
Prescriber Signature or Electronic I.D. Verification: \_\_\_\_\_ Date: \_\_\_\_\_

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

